

## The dog that failed to bark

Tom Burns<sup>1</sup>

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<sup>1</sup>University of Oxford  
Correspondence to Tom Burns  
(tom.burns@psych.ox.ac.uk)

**Summary** UK mental health services have been distinguished by their continuity of care but recently there has been a move to separating consultant responsibility for in-patient and out-patient care. Local examples of the success of this approach have been published but there has been remarkably little careful thought about its longer-term impacts. International comparisons would suggest that there are significant potential disadvantages, including increased bed pressures. Some disadvantages, such as the poor fit with the Mental Health Act and patient dissatisfaction with structural discontinuity are already obvious. A more considered debate is called for.

**Declaration of interest** None.

Inspector Gregory: 'Is there any point to which you would wish to draw my attention?'

Holmes: 'To the curious incident of the dog in the night-time.'

Gregory: 'The dog did nothing in the night-time.'

'That was the curious incident,' remarked Sherlock Holmes.

Arthur Conan-Doyle, *Silver Blaze*

Over the past few years UK mental health services have been experiencing a radical change in practice, with little, if any, public scrutiny or discussion. Separating consultant responsibility for in-patient care from that for out-patient care is a rapidly accelerating silent revolution. In contrast to the introduction of the 'functional teams' (assertive outreach, crisis intervention and home treatment and early intervention teams), it is not driven by an articulated national initiative such as the *National Service Framework*<sup>1</sup> and the *NHS Plan*.<sup>2</sup> Hardly anyone seems to know exactly where it comes from or, indeed, why it is happening. The absence of debate in professional journals is remarkable for what is potentially one of the most significant reorganisations of UK community mental healthcare in the past decade.

Recruiting consultants and patients to a multicentre study (OCTET)<sup>3</sup> of community treatment orders (CTOs) in over 20 trusts across England has revealed confusion and considerable dissatisfaction among psychiatrists about this change. Community treatment orders highlight the poor fit of such divided responsibility with the 1983 Mental Health Act and its 2007 revision. A central feature of the UK Mental Health Acts (in all their forms – England and Wales, Scotland, and Northern Ireland since their origins from the original 1959 Act) is the assumption that the same consultant decides on both in-patient and community care, and the transitions between them.

The UK Mental Health Acts are silent on how consultant responsibility is divided because it was simply never considered that it would be divided. The issue was not raised at all during the Parliamentary scrutiny committee's 5-month examination of the 2007 revision of the England and Wales Mental Health Act.

Who should decide about placing a patient on a CTO? In-patient consultants are currently the responsible clinicians so legally it has to be them. Clinically, however, this is obvious nonsense. It is the community consultant who has to be confident that the provisions are feasible and to make the CTO work. It is understandable that this eventuality was not carefully considered. It is, after all, a fundamental premise throughout medicine that doctors take responsibility for their own clinical decisions and not for those made by others.

In OCTET we found many examples where the divide is being made to work by the exercise of considerable tolerance and collaboration. Consultants meet and agree on who should be on a CTO. Some in-patient consultants accept that it is solely the community consultant's responsibility and make the recommendation on their advice. Even with the best will in the world it is, however, not hassle-free. The position of (Mental Health Act) Section 17 leave becomes anomalous. Section 17 leave is intended for short spells of time to test out the stability of recovery in detained patients. Often it is used for a period of a few weeks before final discharge to informal status or the decision to institute a CTO. Some trusts insist that Section 17 leave be monitored by the in-patient consultant. This requires regular return visits to the ward by the patient or community team staff.

Clearly this is a mess. In some trusts real problems are emerging. This is particularly where in-patient consultants insist on making the decisions to initiate CTOs, with minimal, or even no, consultation with the community team. Not surprisingly, this leads to bad feeling.

### Why has the split of responsibility happened?

The most common explanation volunteered is that the split is a response to concerns about the quality of in-patient care in acute wards.<sup>4</sup> With reducing bed numbers the threshold for admission has risen over the past two decades and the

level of disturbance on wards has increased markedly. Now a third of patients are admitted involuntarily and a further third transfer to compulsory care at some stage in their admission.<sup>5</sup>

Alongside this increase in the severity of symptoms and disturbance, wards find they have to relate to many more admitting teams, often six to eight where it used to be two, maximum three. This increase reflects both an increase in the number of teams (arising from reduced catchment area sizes and functional teams) and also from the move to single-gender wards. This imposes a massive burden on nursing staff serving multiple ward rounds and also diffuses clarity of responsibility and authority for the ward as a whole.

It is these structural and functional aspects of the divide which are generally advanced to support it. In many trusts it is promoted as just one more facet in the move to functional teams deriving from the *National Service Framework*.<sup>1</sup> The in-patient/out-patient split was not included in the framework but, as with the functional teams, it often carries the spoken or unspoken expectation in many trusts that it will save costs by reducing bed occupancy.

Reports of consultants taking over responsibility for in-patient care in congested or dysfunctional wards and establishing effective bed management<sup>6</sup> give endorsement to the split. In the absence of a professional debate, however, the level of support for the change is unclear. There is little evidence of careful consideration of the potential consequences (short- and long-term) of these changes. Some suggestion of what these may be can be gained from looking to the rest of Europe, where in many countries (though not all) this has been the norm. That several countries are attempting to unpick this traditional divide and ensure continuity of care should, at the very least, give pause for thought.

### Effective bed management and service costs

Reducing pressure on scarce in-patient resources has been cited by pioneers of this approach, usually after local success. However, community psychiatry research repeatedly reminds us of the need to distinguish clearly between the effects of innovative systems from the effects (inevitably time-limited and non-generalisable) of the impact of the exceptional individuals who introduce them.<sup>7,8</sup> The in-patient/out-patient split is most firmly established in German-influenced psychiatry systems and this is reflected in the range of bed provision across Europe.<sup>9</sup> This is a complex picture with a number of contributing factors including healthcare culture and investment. However, it is hard not to notice the gradient from high bed numbers in split services such as in Germany, Switzerland, Belgium and The Netherlands, through Scandinavia, which has been moving to erase the split, to the very low numbers in Italy, which has long championed continuity of care. Anyone expecting the in-patient/out-patient split to save costs may be in for a disappointment.

This is as one might expect. Discharge from hospital is rarely of a totally 'cured' individual. It requires a sensitive balance of risk with the judgement that their needs can now be safely met in the community. Intimate knowledge of

the patient's recent progress and the community team's strengths and weaknesses ensures a more confident assessment. An unintended consequence of fragmented care systems is the perverse incentive to shift patients between teams by talking pathology up or down. A powerful disincentive to admitting patients too readily is the sure knowledge of still having to deal with the unresolved issues yourself.

### Discontinuity of care

Psychiatric care is about effective treatments delivered within a trusting, or at the very least a well-informed, relationship. We know that patients value continuity of care very highly and so do mental health professionals. Many staff consider their ability to establish therapeutic relationships as their most hard-won and important skill. We should not underestimate how distressing it may be for patients to lose the security of contact with familiar staff at the point of being admitted to hospital, when they are feeling at their most wretched and vulnerable. We see it as a transfer but many patients experience it as abandonment, even rejection.

### The risks of interfaces

There are also risks in discontinuity at discharge. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness<sup>10</sup> found that death rates immediately after discharge (always a high-risk period)<sup>11</sup> were greater in those discharged from private hospitals back to the National Health Service (NHS) community services. At that time virtually no NHS services had divided consultant responsibility.

### Effects on psychiatry as a profession

What would be the more long-term effects of this rigid divide on our profession? Having worked in Sweden when this was the practice, and having visited extensively throughout Europe and the USA, two consequences seem likely. The first consequence is an increasing polarisation between in-patient and out-patient professional styles. Exclusively in-patient psychiatrists understandably adopt a 'medical model' as their work focuses on the short-term management of acute symptoms. Out-patient psychiatrists (and their teams), engaged predominantly in long-term management, are more psychosocial in orientation.

The eclectic and pragmatic quality of UK psychiatry with its developed social emphasis derives much from continuity. Psychiatrists in the UK have to live with their failures (and their mistakes). It is much harder to sustain an exaggerated confidence in one or other treatment approach; you soon find that nothing works for everybody. Theory-driven, dogmatic psychiatry is challenged by working with patients over years or decades. Those who do not respond to the preferred treatment cannot simply be passed on and ignored.

The second consequence is that a hierarchy also develops with the split. In-patient doctors have a significantly

higher status in those countries where it is established. The relative dominance of UK community mental health services research is probably in part a reflection of the absence of a reduced status in community psychiatrists.

A more focused, restricted remit is not, however, without its appeal. The job is less stressful – one can always obtain respite, albeit temporary, from intractable clinical problems.

Separating in-patient and out-patient care may be the way forward for UK psychiatry but it is far from being an open-and-shut case. There are certainly some real problems with it, which have been raised here. These need to be considered carefully by the profession before we accept a change that everybody seems to think has been decided upon by someone else.

### About the author

**Tom Burns** is Professor of Social Psychiatry in the Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford.

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